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Notice of Independent Review Decision

Date notice sent to all parties: 01/05/15

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Eight sessions of physical therapy

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

Board Certified in Orthopedic Surgery
Fellowship Trained in Spinal Surgery

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

X Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

Eight sessions of physical therapy - Upheld

PATIENT CLINICAL HISTORY [SUMMARY]:

A lumbar MRI was obtained on 05/01/14. There was a 3.5 mm. central/left paracentral disc protrusion at L4-L5 that effaced the ventral thecal sac. This also appeared to compress the left L5 nerve root. Correlation for left L5 radiculopathy was recommended and it was noted the central canal was mildly narrowed at L4-

L5. The remaining lumbar levels were normal. examined the patient on 05/22/14. He was injured on 02/19/14 when he bent over to lift and injured his back. He noted when he walked, his foot would fall asleep and he felt like he had a pinched nerve. He was currently taking no medications. He was five feet four inches tall and weighed 208 pounds. He had no lumbar tenderness or spasms on exam. He was not able to perform "functional tests". Lumbar range of motion was reduced by half and strength was 2 in the right psoas and quadricep. The remaining lower extremity strength was normal, except for the left T. Post., which was 4/5. Straight leg raising was positive on the left and all lower extremity reflexes were 2/2. The MRI was reviewed. The diagnosis was a large herniated nucleus pulposus at L4-L5. Naproxen was changed to Mobic and Tramadol was also prescribed. Therapy was continued and an epidural steroid injection (ESI) was requested. felt it was very likely the patient would need microdiscectomy at L4-L5. Light duty was continued. On 09/25/14, reexamined the patient. He walked with a slow gait and had not made any improvements or had any treatments. The assessment was an L4-L5 HNP. noted the patient had been off of work since February when he was injured and had not had any basic treatments. Therapy and Lodine were prescribed. On 09/26/14, requested therapy three times a week for four weeks. examined the patient in therapy on 10/01/14. He indicated he had received two sessions of therapy, but the doctor told him he needed more and after that, they were just waiting to hear from the insurance carrier. This was in February 2014. He reported since he quit working, he was better because he has not been moving or lifting a lot. Lumbar forward bending was 45 degrees, backward bending was 15 degrees, and right and left rotation was normal. Dermatomal testing of the lower extremities was normal, as was myotomal testing, except the L1, L2 was fair on the right and poor on the left. The L3 was fair on the left and normal on the right. Reflexes were 2+ bilaterally. Therapy was recommended twice a week for four weeks to include therapeutic exercises and activities, gait training, neuromuscular reeducation, manual therapy, and instruction in home exercises. On 10/08/14, on behalf of Travelers, provided an adverse determination for the requested physical therapy twice a week for four weeks. noted on 10/30/14 that the patient's therapy had been denied and he had no change in his condition. His left leg pain was severe and he had been unable to return to his job as a driver. Lodine was continued and noted they would request physical therapy again. performed a Designated Doctor Evaluation on 11/10/14. He reported a history of depression and anxiety and his medications included Etodolac. He complained of low back pain and weakness of the back and foot. His gait was guarded, antalgic, and with some difficulty. He could not stand on his left leg, but could on this right leg with some difficulty. He could not walk on his toes or heels. He had left sided spasm and tenderness in the lumbar spine. Straight leg raising was negative on the right, but positive at 20 degrees on the left. Lumbar flexion was 48 degrees, extension was 20 degrees, right lateral bending was 10 degrees and left lateral bending was 18 degrees. Sensation was decreased on the left at L4 and L5. Knee reflexes were +2 bilaterally and the ankle jerk was +1 on the left and +2 on the right. Muscle strength of the back extensors and abdomen could not be performed. Muscle strength was +3-4/5 throughout the left lower extremity, but 5/5 on the right throughout. The diagnosis

was a herniated L4-L5 disc. felt the patient had not reached MMI, as he required 10 sessions of therapy over eight weeks per the ODG. She felt the patient had not received the appropriate conservative care. To determine return to work, the patient underwent an FCE on 11/19/14. He performed with inconsistent and with submaximal effort, so his physical demand level was listed as indeterminate; however, felt the patient was capable of performing sedentary work. In this FCE, nine days after the Designated Doctor Evaluation, his lumbar range of motion revealed flexion of 30 degrees, extension of 10 degrees, right lateral flexion of 24 degrees, and left lateral flexion of 32 degrees. Motor testing did not detect any gross motor deficit. He also demonstrated below normal grip strength and key grip strength. On 11/19/14, provided another adverse determination for the requested physical therapy.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

a chiropractor who performed the Designated Doctor Evaluation, unfortunately did not recognize the non-physiological aspect of the examination with wide spread weakness in multiple dermatomes. This would not be consistent with the MRI and not consistent with the physical therapist's own report. It is consistent with the FCE that was performed by the Designated Doctor, noting inconsistent and submaximal efforts.

On the basis of the ODG, 10 sessions of therapy over eight weeks is appropriate for the diagnosis of a lumbar sprain/strain or lumbago. It notes when treatment duration and/or the number of visits exceeds the guideline, exceptional factors should be noted, which is not the case currently. The 10/01/14 therapy evaluation noted the claimant had attended two sessions of therapy in February, but it is unclear if he completed those sessions or why it was not completed, if that was the case. His response to the therapy he received is not documented in the records reviewed at this time. The therapist documented normal lower extremity strength and reflexes bilaterally. It has been eight months since he was last seen in therapy and there is no medical documentation as to why after a prolonged hiatus further treatment would be indicated. The patient had a minimal number of sessions of physical therapy when it would have been appropriate, after the incident, and there is no documentation of any condition at this time that would be responsive to physical therapy. The MRI showed minor degenerative changes with abutment of the L5 nerve root. There is no objective condition for which physical therapy is indicated at this time. There is insufficient documentation to support the request, in that there is no information that the patient improved or had effective treatment with his initial therapy sessions as noted above. Therefore, the requested eight sessions of physical therapy are not medically necessary, appropriate, or in accordance with the ODG and the previous adverse determinations should be upheld at this time.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- X **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- X **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**